MDR: M4-02-3506-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $2,565.60 for dates of service commencing on 08/23/01 and extending through 11/08/01.

   b. The request was received on 05/10/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on 06/20/02. Per Rule 133.307 (g) (4), the carrier representative signed for the copy on 06/21/02. The response from the insurance carrier was received in the Division on 07/08/02. Based on 133.307 (i) the insurance carrier's response is untimely so the Commission shall issue a decision based on the request.

4. Notice of Additional Information submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 06/12/02

   "Numerous attempts have been made to collect the outstanding balance on this account, with telephone calls, and reconsideration letters. Reconsiderations have been previously submitted to TWCC under separate cover. (Carrier) has set a rate of $115.00 for Chronic Pain Management reimbursement. We are submitting herewith redacted Explanation of Benefits from four (4) insurance carriers supporting our rate of $128/hour as Fair and reasonable.

We seek full reimbursement for the outstanding balance of $2565.60, along with interest accrued according to rule 134.803."

2. Respondent: The response was not timely and consequently not eligible for review.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 08/23/01 and extending through 11/08/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $24,576.00 for services rendered on the dates of service in dispute above.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $22,010.40 for services rendered on the dates of service in dispute above.

5. Carrier denied date of service 08/23/01 as "C – Negotiated Contract. A reconsideration audit completed on 04/17/02 denies this date, along with the remaining dates, as "**No further recommendation. Full fair and reasonable for chronic pain program has been reimbursed.**" No hardcopy of a contract or letter of release from the contract was noted in the Requestor's dispute packet.

6. The Carrier's initial EOBs denied any additional reimbursement as "M – Reduced to fair and reasonable.". There is no MAR value for ambulatory surgical facility centers; therefore this dispute will be reviewed as reduced to fair and reasonable.

7. The amount in dispute is $2,565.60 for services rendered on the dates of service in dispute above.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has billed CPT code 97799-CP-AP, which is a DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes… HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Medical documentation submitted indicates these charges are for a chronic pain program. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence. The provider has submitted additional reimbursement data: four example EOBs for charges billed for similar services.

The Carrier's response was not timely and consequently not eligible for review. Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;". The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor has provided some documentation to support their position that the amount billed is fair and reasonable. The Carrier's response was untimely. The injured worker attended 17 sessions at 8 hours, 1 session at 7 hours, 4 sessions at 6 hours, 1 session at 5 hours and 5 sessions at 4 hours for a total of 192 hours. The Requestor's Table of Disputed Services indicates they billed $24,576.00. Carrier reimbursed the Requestor $22,079.40. Additional reimbursement of **$2,496.60** ($128.00 x 192 hours billed = $24,576.00 - $22,079.40 carrier payment = $2,496.60) is recommended.

The above Findings and Decision are hereby issued this 20th day of February 2003.

Denise Terry
Medical Dispute Resolution Officer
Medical Review Division
DT/dt

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit **$2,496.60** plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this order.

This Order is hereby issued this 20th day of February 2003.

Carolyn Ollar
Supervisor - Medical Dispute Resolution Officer
Medical Review Division

CO/dt